Exhibit 8

THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

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IN RE: PHARMACEUTICAL	MDL DOCKET NO.
INDUSTRY AVERAGE WHOLESALE	01CV12257-PBS
PRICE LITIGATION	
**********	FEBRUARY 28, 2006
THIS DOCUMENT RELATES TO:	VOLUME: IV
ALL ACTIONS	PAGES: 905-1168

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C O N F I D E N T I A L

CONTINUED VIDEOTAPED DEPOSITION OF RAYMOND S. HARTMAN, PH.D., called as a witness by and on behalf of the Defendants, pursuant to the applicable provisions of the Federal Rules of Civil Procedure, before P. Jodi Ohnemus, Notary Public, Certified Shorthand Reporter, Certified Realtime Reporter, and Registered Merit Reporter, within and for the Commonwealth of Massachusetts, at the offices of Dwyer & Collora, LLP, 600 Atlantic Avenue, Boston, Massachusetts, on Tuesday, 28 February, 2006, commencing at 9:33 a.m.

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VIDEO OPERATOR: Good morning. We are now recording and on the record. This is a continuation of the deposition of Raymond Hart.

RAYMOND S. HARTMAN, Ph.D.
having been previously sworn, testified as follows to direct interrogatories

BY MR. EDWARDS:

Q. How are you today, Doctor Hartman?

A. Good. How are you?

Q. Fine, thanks. When we left off yesterday, we were talking about EAC, and I want to ask you whether you knew that not only did HCFA not implement EAC, but it told its carriers that there should be no drugs paid based on EAC.

A. And I -- I think I -- you -- I responded to that that I had known that the surveys had not been conducted so that it would be, there were no EAC estimates to use, and hence the reliance -- the reliance was on the AWP independent of that equation.

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Q. But HCFA also decided that even to the extent that there were estimates on a case-by-case basis, reimbursement could not be based on EAC. Were you aware of that?

A. I have not seen that general policy statement to that effect.

MR. EDWARDS: What I want to do is mark as Exhibit Hartman 041 to this deposition a copy of a letter from Darlene Debus, D-e-b-u-s, to Grant Stefan and, the Bates Nos. are HHC 9081217. There is an attachment to this exhibit as well which is from Grant Stefan and to all the physicians who wrote about Lupron, and the Bates number on that is HHC 014-0177.

(HHC 908-1217-0177 marked Exhibit Hartman 041.)

Q. Are you familiar with this document?

A. (Witness reviews document.) I don't recall whether I saw this document in this matter or in the Lupron matter. I don't recall seeing it. I may have. I may not have.

Q. Take a look at the third page. It's a

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memorandum from Grant Stefan who apparently was with Medicare to all the physicians who wrote in about Lupron, dated August 6, 1996, correct?

A. Well, I see that the letter is addressed to Grant Stefan and at Blue Cross Blue Shield of North Dakota.

Q. I'm asking you to look at the third page.

A. I know, but you were saying did I see that he was with Medicare, and I'm -- I'm trying to -- I see a -- I see a Medicare heading to this memo, and I see Grant Stefan's name on it. I'm trying to make consistent the fact that I see him at a Blue Cross Blue Shield of North Dakota on the first page of what you gave me, and then something where it seems as if there's --

Q. Right. It would appear that he's a carrier or he works with a carrier.

A. Yeah. That's what I mean, so that I didn't -- I thought you were saying he was somebody at Medicare. It seems that he's with a carrier to me.

Q. Right.

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A. Okay.

Q. I agree with that.

A. Okay.

Q. And if you look at the first sentence of his memorandum to all physicians who wrote in about Lupron he says, "The regional office of HCFA has instructed me to write this letter retracting my request for invoices made in my memo to you of July 11, 1996." Do you see that?

A. I do.

Q. And then if you look at the letter itself, on the first page in the third paragraph he says in the fourth sentence, "Therefore, at this time, there should be no drugs paid based on EAC."

A. Or the -- in the letter now. I'm sorry. Okay. I was still back on the memo. I'm sorry. Where?

Q. Do you see where he says in the third paragraph, "Therefore, at this time, there should be no drugs paid based on EAC."

A. I see that in that paragraph. Let me just look a bit at the -- (Witness reviews document.)

Q. Does this have any impact on your opinion that the federal policy at this time was EAC?
A. Well, what I think it -- it accords precisely with what I had said, that I see in the second paragraph that there's -- there's a suspension of any data collection efforts through surveys, and as I mentioned before, the surveys were not going on, and so that if there was no survey data available for the EAC, they did not know what it was, and, therefore, the reliance fell back on AWP. And I've expressed that in my -- in my report, and it -- it doesn't change what the statute says, and it doesn't change how I've interpreted the historical facts surrounding the statute as laid out in my declaration. So, this doesn't change my opinion.
Q. So, it's your opinion that, even though this document says there should be no drugs paid based on EAC, it was federal policy at this time to reimburse based on EAC.
A. I am -- I am not a lawyer or I have not -- I am not an expert on the interpretations of the

Medicare statute. I understand the facts to be as I've stated them in my declaration, and they accord with what I see in this -- in this letter and this memo.
MR. EDWARDS: I'm going to mark as Exhibit Hartman 042 a copy of a letter from Donna Shalala to Tom Bliley, chairman of the House Commerce Committee, dated May 31, 2000. The Bates numbers are HHC 0010359 through 0362.
(HHC 0010359-362 marked Exhibit Hartman 042.)
MR. EDWARDS: We're just waiting --
THE WITNESS: I understand.
MR. EDWARDS: -- for the document.
A. (Witness reviews document.)
Q. Have you ever seen this document before?
A. I don't recall among the many documents that I've seen whether -- that this has been one of them.
Q. Do you know who Donna Shalala was?
A. She was a -- my recollection is that she was a Clinton cabinet member, and she may have been

the director of HHS. I can't really recall.
Q. And HCFA was part of HHS, correct?
A. That's my understanding, yes.
Q. And Medicare was part of HCFA?
A. That's correct.
Q. Correct. If you look at the third paragraph on the first page of this document, she says, "Because the estimated acquisition cost approach had proved unworkable in 1997, the President proposed legislation to pay physicians their actual acquisition costs." Are you familiar with that legislation?
A. The legislation is -- given that it's talked about proposals and proposed legislation, and if it appeared in any of the CFR materials that I've cited in the footnotes relating to Medicare or some of the documents leading up to that, I may have read it. I don't know. This proposed legislation is too general for me to be able to know exactly what she means by this.
Q. She goes on to say, "Physicians would tell Medicare what they pay for drugs and be reimbursed

that amount rather than the administration developing an estimate of acquisition costs and basing payment on the estimate."
So, the proposal was to reimburse physicians at their actual acquisition cost, correct?
A. That's how I read those two sentences.
Q. And do you know why this legislation would have been necessary if it already was federal policy as you have testified to reimburse physicians based on estimated acquisition cost?
A. Well, the federal policy to which I've referred to is -- are merely the CFR and the Medicare regulations as they -- as they stand as written and as you've given them to me. So, I take that as an expression of congressional policy and regulation.
We do know and we've all agreed that the estimated acquisition survey that -- the surveys to estimate the acquisition cost proved unworkable, as they're saying here. And so, the President is asking that -- that rather than a survey being done,

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that there's a self-reporting on the part of physicians that they pay -- the estimated acquisition cost would really be the acquisition costs of the physician. So, they're asking them to do the billing at the acquisition cost, the average of which would be the estimated acquisition cost overall.

So, this fits in with the fact that the surveys proved unworkable, and I see in the next sentence it says that it did not adopt the Administration's proposal, and they continued to relate it to an AWP-based reimbursement rate, which I understand to be the case, and I think I've probably cited that fact in my declaration or somewhere in one of my declarations.

Q. So, it's your testimony that the spread for Medicare was zero by statute when Congress, in fact, adopted -- I'm sorry -- rejected a statute that would have made it zero.

MR. NOTARGIACOMO: Objection. You can answer the question.

A. Could you rephrase that -- that question.

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Q. Is it your testimony that it was federal policy that the appropriate spread was zero by statute, even though Congress rejected a statute that would have made it zero?

MR. NOTARGIACOMO: Same objection.

A. I have based my spreads on my reading of -- of the expression of Congress in the CFRs relating to what reimbursement should be. And I -- and I know there's -- there's a -- a mountain of -- of legislative and statutory history behind that, and I have not examined that in any way to draw any conclusion other than to take the regulations as I see them written and as expressed in my footnote.

Q. Doesn't the fact that --

MR. NOTARGIACOMO: Objection. He's not finished with his answer.

A. Yeah, let me just -- I just want to make -- I just wanted to cite which footnote it was indeed in. In Footnote 13.

Q. Doesn't the fact that Congress rejected zero by statute in the Balanced Budget Act of 1997 suggest that your interpretation of the words

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"actual charge" in the regulation as meaning acquisition cost is incorrect?

MR. NOTARGIACOMO: Objection.

A. No. My interpretation stands as it does and as supported by the footnotes that I've -- I've cited.

Q. So, it's your testimony that, even though Congress rejected zero by statute, HCFA went ahead and adopted regulation implementing zero by statute.

MR. NOTARGIACOMO: Objection.

A. You're posing a question to me, the antecedent of which I don't know whether is true or not. I see a paragraph here where it's saying Congress did not adopt this proposal in one letter. I don't -- I don't know if there was a letter following this that -- that refined this. I look at the statutes as they are stated, and that's -- that's as far as I've taken it.

Q. You don't have the requisite expertise to testify definitively in this area, correct?

MR. NOTARGIACOMO: Objection.

A. I am not an expert on the statutory

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history of -- of Medicare, period.

Q. Do you have Exhibit Hartman 040 there in the stack?

A. I do.

Q. This was the regulation implementing the Balanced Budget Act that we discussed yesterday. Do you recall that discussion?

A. I do.

Q. And we had a discussion about the meaning of the words "actual charge" in that regulation, correct?

A. We did.

Q. Now, are you going to make any further inquiry to determine what those words mean and how they were interpreted by the medical community?

A. If asked to, I may. I -- I point out that in the -- in the paragraph that we just read, it is certainly the case that Ms. Shalala is making the -- the argument that the amount charged should be the amount that physicians pay. You're telling me that that was -- that alternative was rejected. I -- I see support in this -- in the letter of Ms. Shalala

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that the charged amount is what they were talking about, what the physicians paid for the drugs. Now, whether that was implemented as an alternative or whether Congress repudiated that or didn't allow it or didn't implement that, that's -- that's something that I don't have the -- have knowledge about.

Q. Well, you said if asked to, you may make further inquiry as to the meaning of the words "actual charge" in the regulation. If I ask you to, will you do it?

MR. NOTARGIACOMO: Objection.

A. If you ask -- ask me to, I'd be delighted to consider that and ask the -- my counsel whether they would want me to do it.

Q. Well, I'm asking you to do it, okay? And I'm also asking you whether if you learn as a result of your inquiry that your interpretation of those words was incorrect, you will correct your report.

MR. NOTARGIACOMO: Objection.

A. I -- I would have to defer to my counsel for what they would want me to do.

Q. You wouldn't insist on correcting your

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report, just as a matter of personal pride?

A. I don't take my report to be incorrect as it stands.

MR. EDWARDS: I'll mark one more document in this series. This will be Exhibit Hartman 043. It's a letter from Nancy-Ann Min DeParle to Congressman Pete Stark, dated January 26th, 1998. The Bates Stamp is HHC 001-0363

(HHC 001-0363 marked Exhibit Hartman 043.)

A. May I inquire as to the province of this -- I see a stamp of January 26th, 1998. Was that the date the letter was sent or is that something that was added afterwards, do you know?

Q. I don't know.

A. Okay.

Q. Do you know?

A. Do I know? I wouldn't have asked if I knew.

Q. So, in this letter, Ms. DeParle talks about the proposal?

(Computer sounds.)

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THE WITNESS: The last two days have been erased.

MR. EDWARDS: The record should reflect that a computer just started to squeak and squeal, but we're okay.

Q. In the second paragraph of this letter, Ms. DeParle talks about the proposed legislation that would have removed the markup currently being paid above the true marketplace wholesale price. Do you see that?

A. Well, I -- I see in the first paragraph it says that, "While Medicare policy is to pay the AWP, the prices reported by commercial sources of this information do not reflect -- the prices reported -- " oh. "The commercial sources do not actually reflect the true wholesale price or the true price -- " she calls it a wholesale price "-- in the marketplace." Is that what you're getting at? Is that or the sentence?

Q. Well, I was referring to the second paragraph. You're reading from the first paragraph?

A. Okay.

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Q. The third paragraph says, "The proposal, which OIG supported did not survive the legislative process." Does that remove any doubt that you may have had in your mind as to whether zero by statute was rejected by Congress?

A. As I say, the -- I read the Medicare statutes as they appear in the CFR or the Medicaid regulations -- or the Medicare, I'm sorry, regulations. If, indeed, Congress had not intended to introduce a measure of reimbursement that was the lesser of several measures, and if all of these individual letters that you've pulled out from what must be a voluminous record back and forth of what was going on was saying that they -- that there was -- that any reliance on anything but AWP is -- is not going to be allowed, I don't understand why it appears in the -- in the CFR. I've taken the CFR as a statement of what Congress meant, as I -- I know there were letters going back and forth and debates about what should be what, and I've looked at the final regulations that have appeared, and I know that there was concerns that AWP allowed for margins

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that were too high and there were motions to move to ASP that only were finally implemented in 2005, and that the -- going to 95 percent of AWP at 85 percent of AWP were movements in that direction, but if what you're telling me is that the legislative process has continued to reject any kind of bill charge acquisition cost, then I don't understand why it appears in the CFR and in the regulations that talk about reimbursement. But again, I'm not an expert on -- on the -- on this -- on the statutory implementation of -- of or the statutory articulations of these standards. I see the standards as they appear in the record.

Q. Well, Ms. DeParle -- DeParle says, "The proposal which OIG supported did not survive the legislative process. Instead, Congress provided in Section 4556 of the Balanced Budget Act of 1997 that program payment be made at 95 percent of the AWP. Do you think she would have said that if the Balanced Budget Act of 1997 had, in fact, implemented zero by statute?

MR. NOTARGIACOMO: Objection.

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A. Well, again, when you're saying "zero by statute," you know, let's -- let's be clear of what that means. It's -- when you're saying "zero by statute" you're saying that they -- that they wouldn't have implemented a statute that says you pay the lesser of AWP or 95 percent of AWP or the actual bill charged or the estimated acquisition cost.

So, you know, if -- if Congress had decided this and this was what was to be written into -- into the regulations, I don't know how the Medicare regulations read as they do read.

Q. Unless you --

A. And that's something I will leave to someone who's an expert on the Medicare regulations. It's not my -- I can only read what they state and what they imply for reimbursement.

Q. It goes on to say, "Furthermore, no provision was made for controlling any rise in the AWP." Are you aware of the discussions that were had at the time of the adoption of the Balanced Budget Act of 1997 concerning situations where a

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manufacturer might increase AWP in order to create spread?

A. There were certainly cases where that was occurring, which have -- have been cited in my report. There certainly was an attempt to begin to control costs on the part of managed care of prescription drugs. And the focus of that -- those efforts were the AWPs of self-administered and physician-administered drugs. So, yeah, I'm aware that that was going on.

Q. You say there were cases where that was occurring, and HCFA was aware that that was occurring, correct?

MR. NOTARGIACOMO: Objection.

A. I'm saying it was occurring, and as we look back now, we can see that it was occurring.

Q. And do you know whether HCFA and Congress, for that matter, were aware that that was occurring?

MR. NOTARGIACOMO: Objection.

A. Well, I think we've plowed a field of anecdotal citations yesterday where increasing information was becoming clear that reimbursement

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based on AWP allowed for large spreads, large returns to practice. And over the '90s, culminating in the litigation that we find in the early 2000s that that understanding became more pervasive and it -- it stimulated the Congress to act as they finally did in 2 -- in the -- in the prescription -- Medicare Prescription Drug Improvement and Modernization Act and in third-party payers beginning to assess how they were doing reimbursement.

Q. There are two ways to create spread, correct? One way is to discount the transaction price; the other way is to increase the AWP, is that right?

A. That's right.

Q. And HCFA was aware of both ways in the 1990s, correct?

MR. NOTARGIACOMO: Objection.

A. I -- that -- those types of activities were occurring in the '90s. I'm obviously looking for a particular discussion of this -- of these examples. I mean, it -- at Page 53, I describe the

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-- both of the issues that you're talking about, and this is a summary from MedPac that is talking about reimbursement, and it -- it shows exactly. It's stating exactly, Paragraph --

Q. Did you say Page 53?

A. Paragraph -- if I said Page 53, I'm sorry. Paragraph 53, Page 36.

Q. And you're referring to your report?

A. I'm referring to my December 16th declaration. And I've -- in 53-A I cite, and with emphasis in bold, that there were two -- two alternative strategies. You could either -- to increase market share. You could either raise the AWP and leave your ASP unchanged, which would be the preferable strategy, but that was -- it was clear to manufacturers that AWP was becoming a focal point, and that increasing AWP might draw attention of regulators, and then the alternative way is lowering the ASP and keeping the AWP constant. And that would also increase the spread, and that's discussed as an alternative method by MedPac. And so this -- this -- this behavior -- obviously when we look back

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at Lupron, this behavior was going on between Lupron and Zoladex starting in the mid -- early to mid '90s, and awareness was permeating the industry, but not everyone was aware of it. Not everyone was aware of the -- that the completeness of it and how pervasive it was; that they acted on it in the ways that they have since that awareness has solidified and galvanized statutory changes and -- and reevaluations of how private third-party payers do reimbursement.

Q. I take it you're not in a position to testify that HCFA was deceived by any of this, correct?

A. Well, I think we're -- we're returning to the -- the -- you're -- your word of choice yesterday is "deceived" or "deception." The -- the question that un -- the notion of the inflation of the AWP and its implications were that prices were sufficiently nontransparent; that the extent -- the extent of the spread across all the drugs was not understood by the -- the payers in this market.

And so, when you -- when you talk about

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deception, I am -- I would guess HCFA may have seen a report sometime in the -- in the middle of the '90s where on a particular drug they said look at these spreads. Look what's going on. But there was -- it was not clear how pervasive that was. This was -- this was one of the -- again, placing it within this -- this context of the importance of being unimportant, this was one of the issues that was receiving less scrutiny than other areas for managed care. And so, there was probably an awareness of some of these spreads for some drugs. Does that mean HCFA was not deceived or deceived? The -- the question of finally acting to change your behavior and reveal your preferences and reveal your understanding is to change either your reimbursement formula, as we talked about in terms of revealed behavior, or to change the statutes.

And so HCFA started to understand this. This is not a -- this notion of being deceived, it's -- it's as if you're -- someone's telling you a lie, and one day they say I'm lying to you and suddenly the next day you know. This is something where

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evidence accumulates over time over a broad cross-section of drugs, and your realization is a slow one, because the information comes in slowly to ultimately alter your behavior to reveal different preferences or different economic strategies.

Q. You don't know what HCFA knew, do you?

A. Do I know day to day what HCFA knew? Was I present in HCFA meetings and have I -- have I reviewed all the memos of HCFA and everything else? No, I have not. I have not done that.

Q. So, you're not in a position to say whether HCFA was deceived?

MR. NOTARGIACOMO: Objection.

A. I think I've stated what I'm in a position to say.

Q. Well, take a look at Paragraph 56 of your report. I think this is Exhibit Hartman 023 to this deposition. You say, "The basis for my finding of causation and liability is empirical. It requires a comparison of actual spreads with yardstick spreads," correct?

A. Oh, yeah, I'm sorry. I was looking at the

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second paragraph. That's correct.
Q. So, the basis for any opinion on liability you may give is simply a comparison of actual spreads with yardstick spreads, correct?
A. That's correct.
Q. And you're not in a position to go a step further and render an opinion on whether HCFA was actually deceived by any of those spreads.
A. On a --
Q. Correct?
A. I -- I think I've said what -- what I -- what I can say about what HCFA believed or what -- and what was motivating HCFA.
Q. I believe we established yesterday that HCFA was aware of megaspreads as a result of the Ven-A-Care letter, correct?
MR. NOTARGIACOMO: Objection.
A. I'd need to look at the Ven-A-Care letter again. You've shown me -- I have it here. Okay. So, I have this in front of me, and I know we spoke about several specific paragraphs. If you could direct me back to those paragraphs.

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Q. Well one paragraph we looked at in particular was the second paragraph on the third page, third sentence where it says, "Based on these results, we found that Medicare's reimbursement was excessive and in many cases provided profit margins of more than 500 percent, and in some instances more than a thousand percent."
A. I do see that. I see that the sentence says that the Medicare program -- that the focus there was on fusion and inhalation drugs. So there clearly were a set of drugs that Medicare was receiving information that the types of information -- this was a letter dated in '96 -- which would probably start to reflect understandings and reimbursement strategies in such discussions in '97. So, in the mid '90s to the mid to late '90s, Medicare was getting more letters and seeing more of this -- this kind of data and information that was leading to the discussions that -- that ultimately changed the reimbursement policy.
Q. HCFA would have been aware of the Medicaid best prices, correct?

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MR. NOTARGIACOMO: Objection.
A. The -- the best prices would be reported to CMS under the Medicaid program.
Q. HCFA also would have been aware of the FSS prices, correct?
A. The -- the statutory enablement of sharing that information is un -- I don't know. As a matter of fact, I'm not sure that with the best prices reported under the Medicaid statute, whether there is -- there are proprietary reasons why those are not shared with Medicare. I -- I don't know how much information sharing is -- goes across those different groups that deal with those different prices -- administrative prices.
Q. This is not within --
A. So the extent of awareness is not something that I'm an expert in the sharing of that information.
Q. This is not an area in which you have expertise?
A. In terms of CMS practices, procedures, operations, information sharing, day-to-day running

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of the bureaucracy, no.
Q. Do you know what the FSS price is?
A. The Federal Supply Schedule price.
Q. Yeah, but do you know what it's based on?
A. I know that it is a -- a price that's negotiated with the government for particular government purchasing programs, but what do you mean "is based on"?
Q. You've read the MedPac report, correct?
A. I have.
Q. In fact, you rely on it quite heavily, correct?
A. Well, I certainly rely on the section that deals with physician-administered drugs.
Q. And you don't recall reading in the MedPac report a discussion of the FSS?
A. I don't at the moment. We can visit that chapter, if you'd like.
Q. Do you have the MedPac report?
A. I do.
Q. I'm not sure what exhibit number it is.
MR. EDWARDS: Do you know what exhibit

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number this is?
A. I think we had it from a former exhibit and we have a new exhibit of it.
MR. SNAIL: Is it Exhibit Hartman 020?
A. I've got Exhibit Hartman 026 here.
Q. What I'm referring to, yes, that's it. Exhibit Hartman 026.
A. That's right.
Q. Take a look at Page 165 of the MedPac report.
Actually, let's look at 163.
A. Well, I think -- I mean, it's -- 165 is a useful page to look at in terms of setting -- I mean, my understanding of what the FSS is is exactly what is stated in the third paragraph on the left there, that it's -- prices paid by the VA are affected by various factors. The VA administers the Federal Supply Schedule, and that's what governs the purchases and the prices and certainly bulk discounts are given under the Federal Supply Schedule. So that being said, do you want to redirect me to 163?

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Q. Yes.
A. Okay.
Q. In the second paragraph it says, "Another way to create a new benchmark would be for Medicare to base its payments on the FSS prices. Generally, under the FSS, the price for a drug may not be higher than the lowest contracted price paid to a manufacturer by any nonfederal purchaser." Is that consistent with your understanding?
A. I -- I understood the FSS to be as stated on Page 165 and what it did and that it was -- it was a -- when I've looked at the prices on the FSS, they -- the FSS, they are certainly prices that are lower than many -- most of the other prices. The fact that they are based on the lowest contracted price paid to a manufacturer by any nonfederal purchaser, I didn't -- did not know that that was how they essentially negotiated that price. But I knew that it -- it led to the -- to the low prices that we see. So -- and, again, this is -- I see this in a section of methods based on alternative benchmarks, all of which are showing that in 2003

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it's reflecting the growing industrywide awareness over the past seven to ten years of the problems of a reliance on AWP and the alternatives are ASP and the Average Manufacturer Price. The AMP, which it is my -- well, the AMP and here they're saying the FSS.
Q. If Medicare had adopted the FSS, would you conclude that there was no liability and no damages for Classes 1 and 2 in this case?
MR. NOTARGIACOMO: Objection.
A. I think my -- my description of my liability threshold is -- is fairly clear in what it's based on, and we've spent a lot of time talking about that yesterday. And if the prices -- if the prices were charged under Medicare -- or reimbursements were paid under Medicare such that those reimbursements led to spreads that would -- did not exceed the 30 percent liability threshold, then they would not attain liability under -- they would not reach that speed limit, as we described it yesterday, of 30 percent in my -- that's used in my declaration.

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Q. Well, I -- I believe you've testified that under your revealed preferences theory, knowledge of spreads is not enough. There has to be knowledge plus conduct.
A. Well, knowledge is a -- is a difficult -- difficult thing to quantify, and there's different levels of knowledge, and people may know a lot of things about a market. And knowing that doesn't necessarily mean that that's where the market has to -- the equilibrium conditions have to gravitate to.
You have to reveal -- you ultimately have to commit to something based on what knowledge you have or what knowledge you don't have. And that's when you finally step into the market and you say okay, this is what I'm doing. These are the prices I'm going to pay or these are the reimbursements I'm going to agree to. And so, it is based on knowledge, and the more knowledge there is, the more informed that revelation of preferences or behavior is.
Q. And is it your testimony that the conduct of HCFA in 1997 in trying to get Congress to pass a

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statute that would have based reimbursement on acquisition cost is not sufficient conduct to satisfy your revealed preferences theory?
A. The -- certainly the conduct that the information that we see and the -- that is -- was gathered and accumulated over this period of time was reflected in much discussion that we see in the -- in the documents, but it led to decisions about reimbursement at the times those decisions were made and implemented as I read them in the -- in the CFR.
Q. Do you think it's fair to blame the manufacturers because Congress wouldn't let HCFA change the reimbursement formula?
MR. NOTARGIACOMO: Objection.
A. Well, I -- you know, I've -- I'm not an expert on fairness or blame. I'm -- I'm an economist. I'm coming -- I come to a market. I see how expectations are formalized into agreements to reimburse at certain rates. I see what the historical precedence for that is and what -- how third-party payers agree to pay and how Medicare agrees to pay and how they might be struggling with

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that payment, and then I'm -- I'm asked to look at what manufacturers did, observing a certain payment structure and a certain set of behaviors, and I'm asked -- I was asked to evaluate whether those discussion and those -- the limited information or the growing information but the revealed preferences as they existed, whether the manufacturers took advantage of that.
(Computer sounds.)
THE WITNESS: You're just doing that to rattle me, aren't you.
A. Whether --
Q. See, whenever I don't like an answer, I've made a little arrangement here.
A. I think it was the question that it was responding to. I've been asked to -- you know, there are allegations of manufacturer behavior of a -- of did they do -- was there a -- an inflation of prices, an increase of spread or increase of return to practice such -- such that the market was not sufficiently agile to respond to that so that they -- that they could -- that that -- that they could

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avoid any kind of over payments that -- that were generated by that. And that's what I've been asked to evaluate.
Q. Well, HCFA was sufficiently agile, but Congress wouldn't let them. Do you think it is appropriate, from an economic standpoint, to hold the manufacturers responsible for a legislative policy decision?
A. You're asking an ethical or a fairness question. I'm not -- I'm not a philosopher in fairness or equity. I'm -- I'm describing a market. I'm describing what happened with that market, and I'm describing the implications of that market, and I haven't been asked to render any kind of opinion about fairness or --
Q. No, I'm asking for your views as an economist. As an economist do you think it is good economic policy to hold private actors liable for federal government policy decisions? I mean, as an economist, doesn't that make your hair stand on end?
A. I -- the -- my -- the expertise that I've been asked to render in this case is not normative.

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It's not -- is it -- is it welfare improving? Is it -- is this Pareto optimal? Is this fair or anything like that? It's purely positive. I'm just saying look, what's the state of the world? How did people price and -- and strategically make use of a system of reimbursement practices? The -- you know, that question can be turned on its end. You can look at the paragraph that we just looked at, Paragraph 53, where there are these very large spreads that were revealed by manufacturers for the drugs Vincasar and for Lupron and Zoladex. And so, I mean, is it fair to allow companies to take advantage of a system when the system is -- responds the way it does to information and slowly -- and slowly adjusts the way it does, and that it's not -- that it hasn't -- it hasn't responded adeptly enough. Is it fair for these companies to exploit it in this way -- that is well documented. And I haven't been asked to render a question about that -- fairness there either. I've been asked to render a question merely what are the economic impacts of those -- of that behavior. That's all I have a done.

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Q. Do you know whether HCFA ever considered implementing the Federal Supply Schedule as a reimbursement rate?
A. I would assume you -- we've already established the fact that I'm not -- I was not on the distribution list of all of the HCFA memorandum and memos that dealt with alterations in the reimbursement rate. So, I -- I wouldn't know whether they did or not. I would assume it would be one thing that -- that they've -- that many people probably proposed a variety of alternative methods to do it, and so that, yeah, it wouldn't surprise me if they did.
MR. EDWARDS: Let me mark as Exhibit Hartman 044 and Exhibit Hartman 045 two reports, one is an OIG report entitled "Comparing Drug Reimbursement: Medicare and Department of Veterans Affairs," November 1998. Exhibit Hartman 045 will be OIG, "Medicare Reimbursement of Prescription Drugs," January 2001.
("Comparing Drug Reimbursement: Medicare and Department of Veterans Affairs" marked

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Exhibit Hartman 044.
("Medicare Reimbursement of Prescription Drugs" marked Exhibit Hartman 045.)
A. (Witness reviews document.)
Q. Have you seen either of these documents before?
A. I think I have. It's -- at some point I -- I just had all the OIG documents -- well, not all, but relevant ones -- I asked to have them produced for me, and I -- and I skimmed them, but I, you know, I can't say specifically.
Q. And if you look at Page 8 of Exhibit Hartman 044, there is a comparison of what the VA pays for 14 drugs to what Medicare pays, correct?
A. That's correct.
Q. And in some cases, Medicare pays over a thousand percent more than the VA pays for particular drugs, correct?
A. That's correct.
Q. Do you know what happened to the proposal that HCFA based its reimbursement rates on the FSS?
A. It -- it clearly hasn't been articulated

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in any reimbursement standard put forward by Medicare. So I know that.
Q. These indication -- indications of spreads of more than a thousand percent for particular drugs acquired by the VA would suggest that that would be the difference between the lowest contracted price paid to a manufacturer by a nonfederal purchaser and the AWP, correct?
A. That or 95 percent of the -- I -- I'd have to see the exact date.
Q. Right, 95 percent.
A. 95 percent of the AWP.
Q. I think you're right.
A. Yeah. That's right. So, this -- these spreads will certainly be more than the -- a spread based on the average sale price or the average acquisition cost, because it's based on the lowest sale price in that distribution.
Q. It --
A. But they're large spreads that, again, are informing HCFA and Medicare that AWP based reimbursement rate is costing them money. It's

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costing the taxpayers money.
Q. And this information was also available to private payers, correct?
A. To private payers that were focusing on this particular -- I mean, it was -- this was publicly-available information.
Q. Well, FSS prices are publicly available, aren't they?
A. I am not sure. I would assume -- I don't know.
Q. Well, take a look at the MedPac study again, Page 163, Exhibit Hartman 026.
A. And I'm sorry. What page was it? Did you give me a page?
Q. 163. In the third paragraph, last sentence, it says, "Administrative burdens would be modest, since FSS prices are publicly available."
A. I'm sorry. In the -- 163.
Q. Last sentence of the third paragraph.
A. Of the third -- oh, there, okay. Yeah. Yeah, so certainly at the time of this -- this writing, it -- this is -- you know, MedPac is saying

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this over -- I -- the reason I hesitated is that I know with best price for Medicaid that -- that that is something that's proprietary and has been. There may be changes in that, too, with the changes that have been occurring with the -- with recent Medicare revisions. So, yeah, as of the writing of this, it's saying they were publicly available. I would have to look at the stat -- at the practices and procedures of whether this was also considered something that was proprietary and, I don't know, of strategic importance to a given manufacturer.

Q. Does the fact that there was publicly-available information on thousand percent spreads have any impact on your determination that the appropriate expectation yardstick is 30 percent?

A. The -- the yardsticks that are built into my determination of liability are what is reflected as they've been described in revealed preferences for what was agreed to be reimbursed. And we're seeing changes in -- and that's what governed reimbursement for a long period of time as more and more of this information became available. And so,

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the fact that this one document appeared did not mean that everybody went out and said we're going to change our reimbursement practice so that we can defeat this spread.

What the -- the allegations in this case are that there were a set of expectations that are revealed by how people reimburse, and the manufacturers, knowing that, said, we can take advantage of this with return to practice.

And so, you -- you continue to show me information that I fully agree was out there, and, you know, whether the Federal Supply Schedule, in my opinion, is not one that is -- is a useful document to get at spreads, but it's just one of many saying that spreads are high measuring in a variety of ways for a variety of drugs, and the full extent of that only became clear fairly recently within a number of years -- by "fairly clear," it was sufficiently knowledgeable that it was broad enough over all the drugs and it became -- it goes to the radar screens of the payers to say it's time we dealt with this, and that it revealed itself in changes in the

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reimbursement practices.

Q. You say that various government reports inform market expectations, correct?

A. I have said that various government reports that have -- yeah, I mean, all government reports inform expectations.

Q. Including the reports we just looked at which talk about spreads in excess of a thousand percent, correct?

A. I've just admitted this kind of information has been slowly informing expectations so that we see an actual behavioral change in what is reimbursed and what people agree to reimburse. And so that what informed expectations and revealed what was the revealed preferences at the beginning of this class period and what was hardwired into the reimbursement rates over much of the class period were what was reflected in the early '90s.

Q. And you can't rule -- excuse me, you can't rule out the possibility that private payers were thinking, well, my expectation is that spreads vary all over the place. There may be a thousand-percent

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spreads, but my preference as revealed in my contracting practices is to reimburse at AWP minus 15 percent.

A. If -- you've shown me a document --

Q. You can't rule out the possibility --

MR. NOTARGIACOMO: Objection.

A. Can I --

Q. -- payers went through that thought process?

MR. NOTARGIACOMO: Let him answer one question at a time. Which question do you want him to answer, the first one or the one you just posited?

A. I mean in direct response to the question of ruling that out, you put in front of me yesterday Exhibit Hartman 035 where we see in 2004, and I think there was concomitant deposition testimony which I don't remember who it was but it's not really relevant. Oh, Mulroy. It's -- if I found over the period of the '90s that these kinds of analyses were going on and -- and people were focusing broadly across all the drugs and realizing

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this is a -- this is a difficulty, and we're going to -- we're going to choose to continue to allow these spreads to be this high, that would indicate that there was more -- a cognizance of that -- that fact and an acquiescence into the impact that the -- the impact of the overcharges. It wouldn't change the fact that the overcharges were taking place. But I have -- I've seen -- as with the discussions in HCFA and the statutory discussions in Congress, there -- the government was beginning to realize that there were these -- these problems with spreads. I'm finally seeing it in very recent third-party payer documentation. And I see one where they're making some decision saying for now, we're not ready to change. That doesn't mean that they're not going to reveal their preferences a year from now, but they're starting to focus on this part that is of -- as Professor Berndt has said of all of the subjects of managed care is one of the smallest and least subject to scrutiny, and so the -- I don't see any evidence that there was enough of an understanding to characterize the kind of

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acquiescence you're saying. We know these spreads. Let's embrace them. We want -- do we want to pay more? We want to be screwed.

Q. You can't rule out the possibility that the type of analysis that Blue Cross Blue Shield of Massachusetts went through in 2004 was being undertaken by payers all over the place in prior years, correct?

A. I have seen countless discovery documents that demonstrate that when third-party payers are -- when it's made clear to them how much they're paying for a physician-administered drug under a medical benefit, in the words of Ernie Berndt, they're flabbergasted. I've seen document after document of that. Now, I haven't seen any that say oh, yeah, we knew that. We love it. We want -- we want to pay -- we wish they'd raise the -- we wish they'd raise the prices more. I've seen nothing like that.

Q. Do you cite any of those documents in your report?

A. I've -- I've -- I've cited -- I -- I would think so, but I'd have to -- I mean, I can't

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remember the citations.

Q. Can you point any out to me?

A. Well I just gave you Ernie Berndt's citation. So, there's one. And Doctor Berndt has been retained by the independent expert of this court, which seems to think that he understands and has done a thorough review of the documents, the facts, and the issues at point in this court. And in Paragraph 12, the court cites him at Pages 29 and 31, and then also, Doctor Berndt at Page 42 of his report again describes the lack of information characterizing payer understandings of actual spreads, and he says, "In a different industry publication, the executive Advanced PCS --" we're talking about CIGNA being a well-informed payer. We're talking about I think it was United Health Care. Advanced PCS is also a -- a large player in this area. And it reports that in his experience, health plans become flabbergasted as what they've been paying for years for drugs on the medical side because of these dramatic price markups. That's the types of information that I've seen. And I would

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have to go back and count the citations in my affirmative and in my rebuttal declarations, and in this -- and if -- if I'm asked to do that, I -- I can do that.

Q. Have you read the depositions of the people from Advanced PCA that were taken in this case?

A. I have read deposition -- a lot of deposition transcripts. I can't recall whether I read -- I read those.

Q. And do you recall that at least one of them testified that it doesn't matter what reimbursement scheme you adopt, the prices are determined by market forces, and they're going to stay the same.

A. I -- I don't know what -- that's a -- para -- I'd like to see the quote. I'd like to see the context I don't know what.

Q. You don't recall discussing that at your earlier deposition?

A. Apparently we -- we must have had -- had a long colloquy. I don't recall it, I'm sorry to say.

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Q. Let's look at Exhibit Hartman 027.
MR. EDWARDS: For the record, this is the OIG report on physicians' costs for chemotherapy drugs November 1992.
A. Oh, that helps. I'm look for a deposition transcript.
Q. Doctor Hartman, this is one of the documents that you rely on for your 30 percent yardstick, correct?
A. That's correct.
Q. How do you get from the information in this document to 30 percent?
A. Well, this is laid out in introductory fashion. The materials that I've looked at for my liability yardstick is introduced in Paragraph 22, and then the -- the detail of that introductory -- the detail of implementing what is introductory there in terms of using comparator drugs is laid out in Paragraph 59 of the declaration and that includes citing the -- the OIG report and the -- the NOR -- the University of Chicago NORC report -- no, I'm sorry. The OIG report is found and it's not cited

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specifically. It's in Paragraph 59-B referring back to 22-B.
So, this is one of -- of a variety of materials that I examined and upon which I based the yardstick, which was an upper bound of a range of spreads for single-source physician-administered drugs.
Q. Where is the support for 30 percent in this document?
A. This -- in this document I look at Appendix 2, and I look at single-source physician-administered drugs, and I look at the spread on invoice cost relative --
Q. Do you mean -- I'm sorry, do you mean Appendix 3? I think you may have --
A. I'm sorry, what did I say? Yeah, Appendix 3. Did I say --
Q. You said Appendix 2.
A. I'm sorry. I misspoke. Appendix 3.
Q. Sorry.
A. My fault. So, the single-source drugs that I have used and I've looked at spreads that --

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on the invoice cost of the brand name manufacturers, their ASPs, and -- or the oncology wholesalers I see ranges anywhere from 12 to 20 percent below the AWP. And so, again, I'm looking at the single-source physician-administered drugs, which is what I have been focusing on in developing the yardsticks, which is what is made clear in -- in detail in Paragraph 59.
Q. Well, let's take a look at Doxorubincin.
A. The multi-source drug Doxorubicin.
Q. It says 56 to 59 percent.
A. Right. That's a multi-source drug.
Q. Where does it say that was a multi-source drug?
A. There's a column there that says, "single source," and it's yes or no. And so, I have -- so I have looked at those drugs where they're single sources, yes. So, the Cyclophosphamide is not -- officer if I had a mind is a multi-source. Doxorubincin is a multi-source, as is -- well, you can -- you can read them just as easy as I can.
Q. Do you know who manufactures Doxorubicin?

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A. Not that I can recall.
Q. This document has information on both single source and multi-source, correct?
A. It does.
Q. But it's your testimony that the marketplace would not have paid any attention to the multi-source information in this document?
A. Well, in this -- in this particular aspect, I concur with Professor Berndt in that the -- the information on multi-source physician-administered drugs is less reliable, and that's his summary of his review of the evidence, and I agree with that. And I see some of the multi-source -- multi-source drugs here like Interferon are well below the range. It's 9 to 14 percent. There's nothing -- a number of the multi-source -- well, a number of the multi-source drugs have spreads that are -- say relative to the oncology wholesalers I'm looking at here, the Interferon where there's that information and the Cyclophos -- the Cyclophos -- whatever is -- is close to 20 percent in terms of the oncology wholesalers. But I -- I agree with

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Professor Rubin -- Professor Berndt that the information that -- what characterized physician-administered drugs in the early '90s for the most part were single source. The pricing and the information on multi-source was even less scrutinized or understood, and so my focus has been on single source.

Q. Do you rely on anything other than Doctor Berndt for your opinion that the marketplace would not have paid attention to the multi-source information in this document?

A. Well, I think Doctor Berndt has -- I mean, he's raised that in a number -- in a number of contexts with his article on the importance of being unimportant and his review of the data. It's also based on my review of what drugs were out there and what was single source and how important single-source drugs were. So it's based on my review of the -- of the documentary evidence.

Q. What --

A. And -- and Doctor Berndt's --

Q. One of these drugs has a spread of 68

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percent to 83 percent, correct?

A. The -- and could you point me to -- so that's to the oncology wholesalers that you're talking about that -- that you're talking about Methotrexate sodium?

Q. Yes.

A. That is a multi-source drug, and it does show those -- that spread.

Q. And that is below AWP, correct. This is a calculation of the discount below AWP, correct?

A. Since I did not rely on those spreads -- let me -- it is relative to AWP. I want to see if it's the AWP of the generic or the branded. I want to see if it tells me -- if it makes that clear here. (Witness reviews document.) It doesn't make clear. It's relative to an AWP. Whether it's the AWP of the branded version for which it's a generic or its own AWP, I can't tell from it -- the documentation here.

Q. Well, if you have a discount of 83 percent below AWP, if you do the math, what would be the percentage markup above the invoice price that the

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AWP represents?

A. If you have this discount below the AWP for the multi -- for this -- for this multi-source drug, the spread over the ASP, if reimbursement is based on AWP for the multi-source drugs, reimbursement is based under Medicare on meet -- we didn't get into -- I don't know which spread we're talking about or whatever under Medicare, it's based on the median of the generic AWPs, depending on the period of time we're looking at.

But if I'm going to just -- if I'm going to assume that this is the AWP for that drug and -- and this is the -- the price -- on -- the spread -- the amount to the oncology wholesaler, the spread would be somewhat larger than these numbers.

Q. Well, in your expectation yardstick you talk about a percentage markup above ASP, correct?

A. That's correct.

Q. And assuming for the moment that we're talking about a comparison of AWP to ASP here, a discount of 83 percent below AWP would represent a percentage markup over ASP in excess of 400 percent,

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correct?

A. I'd -- I'd want to write that equation down, but it would be bigger than 83 percent. Now, the issue here is that this is not a comparison to ASP. It's to the -- the brand manufacturers' prices are not listed. There was no observation. So, it's a -- it has to do with oncology wholesalers. I'd -- you know, I'd -- I'd need to know the spreads. You know, I'd need more information. But it would be higher -- certainly higher than 83 percent.

Q. Yeah, well, we've done the math, and it's actually 488 percent. So, is it your testimony that you looked at this document, you saw markups of 488 percent, and you concluded that the appropriate expectation yardstick was 30 percent?

MR. NOTARGIACOMO: Objection.

A. I looked at this document and I looked at my primary focus in looking for yardsticks, say, with comparator drugs, were to find drugs that did -- and to get a yardstick that informed relationships of an AWP to transactions prices that were not going to be subject to spread competition; that were free

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of spread competition, because it's where the spread competition occurs where -- that's where Defendants have been alleged and have -- and some have been demonstrated to abuse the reimbursement pattern.

So, in the comparator drugs, I looked at single-source patented drugs that were unique, and for which the AWP provided a reasonable indicator, a reasonable sticker price -- an indicator for the transaction prices. The same thing I tried to do with the single source physician-administered drugs, and I also mention in Paragraph 59-C that Doctor Gaier and I are in agreement of a yardstick for single-source innovator drugs, and this is for all innovator drugs, so it includes self-administered of 20 to 25 percent.

Now, I'm -- I'm looking for -- for my yardstick, I'm looking for drugs that are not affected -- that -- that provide a -- where the AWP provides some reliable knowledge of what the ASP is, and those are single-source drugs. We know with generics that's not the case. I'm not going to -- 'cause I -- in generics that's when the spread

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starts to be used to -- and the -- and the AWP is no longer a signal, even though it may be used for reimbursement.

So, in this particular document, I went to the single-source drugs because -- for all the reasons I've put forth in Paragraph 59.

Q. Are you saying that the marketplace doesn't know that spread competition occurs?

A. I'm saying that the marketplace understands that -- now understands that spread competition occurs -- has certainly come to understand it in the late '90s. But in terms of what got set into place for reimbursement practices and policies for physician-administered drugs, in the beginning of -- of this class period, it is my guess that all but one or two of the class drugs were single source, and that's what was reflected in how people were thinking AWP was a signal for price. And so, that's what informed those decisions about reimbursement and over -- certainly over the '90s, by the late '90s, the OIG reports in self-administered drugs were showing that there was

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spread competition -- that generic spreads were quite -- were much higher than they understood them to be in the early '90s.

Q. What is the basis for your opinion that the marketplace did not know that spread competition occurs?

MR. NOTARGIACOMO: Objection.

A. I -- I didn't say that the market didn't know that it occurred. I'm saying that what -- I didn't -- don't put words in my mouth. I didn't say that.

Q. So the marketplace does know that spread competition occurs?

MR. NOTARGIACOMO: Objection.

A. The marketplace has come to understand, as we've discussed at great length, that spread competition has been abused to move market share. And they are now at both the Congressional level and at the private sector level reevaluating how they're going to reimburse -- coming to -- coming to that awareness, which has taken -- a consolidated awareness -- which has taken close to ten years to

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be reflected in the -- in the ability to reveal preferences and reveal behavior that changes reimbursement patterns.

MR. NOTARGIACOMO: We've been going about an hour and a half --

Q. Are you saying that the marketplace, in looking at information such as the information relating to Methotrexate sodium which show spreads of more than 400 percent -- would not have been able to conclude that, hey, there must be some competition going on here based on spreads?

A. I -- I am saying that this -- this is information that was -- one limited piece of information that helped inform -- begin to inform the market what was happening and that physician-administered drugs were a very small component of -- on any radar screen of any -- of any payers in the early '90s, and the multi-source component of that was -- was very small, was much, much smaller than even physician-administered drugs.

So, when you start to talk about being aware of, this data is out there, but you need to

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have payers saying, okay, we're going to -- we've got to make some decisions about changing what we're doing about how we reimburse for multi-source drugs. And you didn't have -- you didn't have people doing that, because it was -- it was a small component of everything. It was the -- the least -- one of the -- it had very -- it had small importance in the costs they were managing. It was one of -- the multi-source physician-administered drugs were in a minority. And so, it would be a waste of the resources of payers to focus on such small ticket items. They might see this and they say, oh, I've got some more important things to deal with. So, yeah, this stuff was out there. It was -- it was not as important to payers as many other things in managed care were over the '90s, and it's become -- now that managed care has addressed those other issues, it's started to become important that there are -- that this kind of information is being processed.

MR. NOTARGIACOMO: We've been going about an hour and a half. I'd like to take a break.

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MR. EDWARDS: Sure.

VIDEO OPERATOR: The time is 11:07. This is the end of Tape No. 1. We are off the record. .

(Short recess taken.)

VIDEO OPERATOR: The time is 11:20. This is the beginning of Cassette to 2 in the deposition of Raymond Hartman. We are on the record.

MR. EDWARDS: I'm going to mark as Exhibit Hartman 046 a copy of an OIG report entitled "Excessive Medicare Payments For Prescription Drugs," dated December 1997.

("Excessive Medicare Payments For Prescription Drugs" marked Exhibit Hartman 046.)

A. (Witness reviews document.)

Q. Have you ever read this document before?

A. I have.

Q. If you turn to Page 8 it suggests that for the particular --

A. If you can -- I'm sorry. If you can just give me a second here. I just want to make a note.

Q. Is that a grocery list?

A. Just my laundry. I forgot to pick it up.

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Q. If you turn to Page 8 of Exhibit Hartman 046, Doctor Hartman, you'll see that there is a chart depicting spreads of 114 percent to 900 percent, is that correct?

A. By J-Code, that is correct.

Q. And this document would have informed the marketplace in the same way that the 1992 report that we have marked as Exhibit Hartman 027 would have informed the marketplace, is that correct?

A. Well, it's -- let me -- just responding a little more -- we keep -- we keep bringing these documents up in a Barron's article for this or that and what we're informing or not informing. I mean, all of these documents that you're putting in front of me are consistent with what I've testified, that, over the period of the '90s, more and more information -- we're talking about informing the marketplace that there were a set of reimbursement rates that were put in place in the early '90s and which characterized most of the '90s, toward the end of the '90s, and into the early 2000s that characterized reimbursement and characterized what

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the individuals thought as revealed in their reimbursement rates and their reimbursement contracts and by which reimbursement was paid.

And so, information like this became available in various places, but it -- it was -- it was -- it was slow to be -- for that information to be assimilated by the -- by the various payers and by Medicare. And we're talking about what did they know of, what didn't they know of, what were they deceived about, whether they weren't deceived? Information continues to be available. The question is, when is it sufficient for -- when is enough of it available to trigger a revealed set of behavioral changes, revealed preferences and changes in the -- so that institutionally you become sufficiently aware to act on it.

It's like Japanese automobiles in this country. They were slow -- information slowly gathered over time on the quality of those automobiles. The quality was there. Everybody didn't switch overnight. The -- for institutions and for groups of consumers and payers to ultimately

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respond, they have to institutionally be sufficiently aware of it that there is a -- there is a decision that is preferred and acted upon. And so, yes, this information was available, and it informed the market as one more bit of information, but until there are revealed preferences and acting on it, it doesn't change the fact that certain expectations were hardwired into reimbursement formulas that are reflected in my yardstick.

Q. What you're saying is information was available, but it was the revealed preference of the marketplace not to act on it.

A. I'm saying as in any market that is subject to dynamic change and subject to different events, different changes in pricing, that the -- the events -- the understanding of that information in many markets is -- is diffused and slow to be understood, and particularly in markets where there -- it is not a perfectly competitive market. There are institutional constraints on -- on information being exchanged; there is asymmetric information that the -- the information becomes available, but

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it doesn't mean that you can change the -- that you change overnight; that there has to be enough of the information it becomes clear that institutionally in this case payers would act to change what has happened.

So that only when they finally do that have they revealed that it is -- they've become sufficiently aware of what's coming -- what has -- what the -- the implications of the -- of these kinds of spreads are.

Q. Well, let's take what we've been talking about as a hypothesis. Information was available but the marketplace decided not to act on it. What evidence do you have to disprove that hypothesis?

A. That they decided -- that they were fully informed -- you're saying do I have evidence --

Q. They were fully informed, but they decided for other reasons, such as cross subsidization, such as attracting providers to their networks, such as is not being concerned about the particular spread on individual drugs, but being more concerned about provider profitability overall. For all of those

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reasons, they decided not to change reimbursement rates. What evidence do you have to disprove that hypothesis?

MR. NOTARGIACOMO: Objection. Go ahead.

A. I've seen no evidence put forward by any of your experts proving that hypothesis. I've seen evidence that I've cited indicating that -- that when it got down to it, payers did not understand the full implication of this and were flabbergasted when they fully did understand it.

So if such evidence exists, I -- I assume you will put that forward. I -- I didn't see any.

Q. Who do you think has the burden of proof in this case, Plaintiffs or the Defendants?

A. That's a legal issue. I'm -- I'm just doing my -- I'm a mere tiller of truth in the garden of the health care industry.

Q. I take it there is nothing in Exhibit Hartman 046 which depicts spreads of 114 percent to 900 percent that supports your 30 percent yardstick.

A. There's nothing in this document that contradicts my use of my yardstick.

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Q. Can you identify any economic literature that supports the methodology by which you arrive at your 30 percent yardstick?

A. That supports the -- the finding of 30 percent or that supports finding a yardstick, whatever it may be?

Q. That supports the methodology that you use for determining that market expectations of the spread between AWP and ASP were that it did not exceed 30 percent?

A. Well, the finding of the 30 percent is specific to this industry and this set of drugs on this particular period of time in this particular institution. 30 percent is not necessarily going to be a yardstick in other situations, but yardstick analyses are -- are very common in economics. I've cited a variety -- you know, a very small subset of -- of the -- of the tradition of yardstick methodologies in my Footnote 19. And I mean, yardsticks are used to determine but-for situations in a -- in many, many contexts, and we can go through the examples. So that the basic -- my basic

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yardstick approach is very common, and it's supported -- you know, I can add 50 more citations if you'd like.
Q. Well, do any of these --
A. The finding of -- the finding of applying the yardstick here, every -- every application -- you can do it for ratesetting for utilities, and that will differ by -- state by state, depending on the regulatory institutions in that state, what the public utility commission is going to be. So, it could be different -- different numbers.
Q. Do any of the articles you cite discuss expectation yardsticks?
A. (Witness reviews document.) The -- in the -- in the various citations that appear in Footnote 19, the yardsticks are created to measure a variety of things, managerial performance, levels of --
Q. I was asking you about expectations.
A. I know. I'm trying to get there if you'd -- if you'll give me that latitude. Now, the extent to which expectations enter into insurance profits in premia and performance of Social Security, I'd

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have to look more closely to see the -- expectations enter into lots of different industries, and how those expectations -- you know what I'm talking about are the expectations as to what shows itself in actual prices. And so, to the extent that expectations are a part of these yardsticks, I would have to look more closely to see -- to answer that question more fully.
Q. So, as you sit here today, you're not able to identify any economic literature that supports your methodology for determining expectation yardsticks?
MR. NOTARGIACOMO: Objection.
A. Well, there's -- there's ones that I didn't list, there are -- there are surveys about what -- you know, the consumer confidence indices and expectations that are -- that are surveyed in a variety of different measures in macroeconomics where people measure what expectations are. And those expectations could be used as yardsticks. So that expectations are not some magical thing that is isolated to -- to this report. I -- the -- there

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probably could be yardstick studies about what -- about what expectations would be, consumer confidence levels, given certain macroeconomic trends that one could develop that. I haven't looked for that type of thing, but measures of expectations are common, and the yardsticks could be developed therefrom if that were a market and those were issues that one was interested in.
Q. I'm -- I'm still waiting for a specific article. Do you have one?
A. I -- I don't have one at this -- right at this point.
Q. And your theory seems to be that you're going to come up with a yardstick to measure market expectations, but to the extent that there are expectations that haven't been reflected in actual contracts or reimbursement rates and actual contracts, you're going to disregard those expectations, is that correct?
MR. NOTARGIACOMO: Objection.
A. I'm not disregarding any expectations. I'm -- I'm looking at patterns of drug prices that have

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-- that have -- that exist for certain types of comparator drugs and types of spreads that have existed for single-source drugs, and I'm looking at the -- the history of Medicare reimbursement and how that's been reflected in reimbursement rates.
Now, that's -- there are -- there's -- there's changing information over time, and the -- when third-party payers say we're reimbursing on ASP or AWP less 70 percent, that that will reveal to me that enough of this information has been reflected in -- in their behavior.
Q. Take a look at Paragraph 60-G on Page 42 of your report. You say, "Despite the fact that publicly-available information suggesting increased spreads became more prevalent in the latter years of the damage period, TPPs were not able to act on such information for the reasons cited above."
What are the reasons cited above?
A. Well, the reasons cited above are all of the analyses put forward in -- in the declaration.
Q. Can you summarize those reasons for me so I can find them in the declaration?

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A. Well, certainly we've talked about -- we have talked -- I've -- I've cited the -- the information and the analysis found in the -- the judge's memorandum and order in Paragraph 13 about what was the evidence of the -- that third-party payers really knew of in an institutional context what the spreads were for these drugs.

I've cited the -- in Paragraph 16 the -- the fact that prices were not transparent and it was difficult for payers to know what was going on, and this is something that the -- the judge admits to and Doctor Berndt admits to in terms of J-Code issues.

Q. So, you're not offering an independent opinion here. You're just opining on what you think the judge has already said?

A. No. You're asking me for what -- my independent opinion has been summarized from my affirmative declaration on. And everything that is reflected here is reflected in that description about how this market works, how information is processed, whether it's transparent or not

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transparent, how broadly available people act on it. So -- so that's what that's -- that's what that's based on and -- oh, are we still --

Q. That's the end of your answer?

A. I think that's enough.

Q. I want to talk a little bit about your use of comparator drugs. Originally -- I think at your last deposition you said one of the things -- one of the things you were going to do is look at comparator drugs for the pre1991 time period. Do you recall that?

A. I recall hoping to look at drugs pre -- preclass period and for drugs not subject to the litigation, that's correct.

Q. And what happened to that exercise?

A. Well, the -- either the -- the Defendants didn't provide the information going back far enough for me to do that or I was -- I had put in a request and some of the requests were for companies that were not subject to this particular declaration, and I -- that data was not forthcoming. And I list in Table -- Table 3-A and 3-B drugs that I had asked

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for for data, but I received -- I did -- I didn't receive -- I received very little of that. And so I had to use the data that -- that was provided, and it was essentially drugs that met the criteria of a drug that would not need to use spread in a nontransparent way to compete; that it would compete on its own merits. And the AWP would be a -- a signal for the transactions prices of a drug not requiring that kind of spread competition.

Q. You said you were also going to look at drugs not subject to this litigation. What happened to that?

A. The -- the list that I had put together was -- the data just was not -- I was told the companies were not going to provide it or we couldn't get that ASP information.

Q. Well, do you recall making a request for IMS data in order to do the analysis of comparator drugs that you wanted to do?

A. I recall asking for IMS data, and I'd have to go back and look at that request. The IMS data turned -- I was -- I was interested in that when --

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when the self-administered drugs that were sold at retail were more at an issue. And so, I was interested in that data in that regard more than in the physician-administered side. The type of IMS data I was asking for -- I was still asking for IMS data for these drugs in another context, which I haven't -- I have yet to receive from Defendants.

Q. Can self-administered drugs serve as comparator drugs for physician-administered drugs?

A. If -- if self-administered drugs meet -- meet a criteria where they don't need to compete on spread competition, it would be something that I would -- I would consider looking at.

Q. Do you recall that one of the drugs you sought data on was Pravachol, which is a BMS drug?

A. I don't recall specifically.

Q. And do you recall that BMS produced the IMS data with respect to that drug?

A. I don't -- I'd have to check with -- with the team.

Q. But it does not appear in Table 3 as a comparator drug. Can you tell me why?